February 13, 2009

HOUSE BILL No. 1086

DIGEST OF HB 1086 (Updated February 11, 2009 12:02 pm - DI 97)

Citations Affected: IC 27-8; IC 27-13.

Synopsis: Assignment of benefits. Specifies requirements with respect to an assignment of benefits under a policy of accident and sickness insurance or a health maintenance organization contract.

Effective: July 1, 2009.

Fry

January 7, 2009, read first time and referred to Committee on Insurance.
February 12, 2009, amended, reported — Do Pass.

February 13, 2009

First Regular Session 116th General Assembly (2009)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2008 Regular Session of the General Assembly.

HOUSE BILL No. 1086

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-5.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]:

Chapter 5.9. Assignment of Benefits

Sec. 1. As used in this chapter, "assignment of benefits" means a written instrument that:

(1) is executed by a covered individual or the authorized representative of a covered individual; and

(2) assigns to a provider the covered individual's right to receive reimbursement for health care services provided to the covered individual.

Sec. 2. As used in this chapter, "covered individual" means an individual entitled to benefits under a policy.

Sec. 3. As used in this chapter, "health care services" has the meaning set forth in IC 27-8-11-1. The term includes ambulance services.

Sec. 4. As used in this chapter, "policy" means a policy of

accident and sickness insurance (as defined in IC 27-8-5-1).

Sec. 5. As used in this chapter, "provider" has the meaning set forth in IC 27-8-11-1. The term includes an ambulance service provider.

Sec. 6. (a) Except as provided in subsection (b), if:

(1) a policy provides coverage for a health care service;

(2) the health care service is rendered by a provider that has not entered into an agreement with the insurer under IC 27-8-11-3; and

(3) the provider:

(A) has an assignment of benefits from the covered individual to whom the health care service is rendered; and

(B) provides written or electronic notification to the insurer that the provider:

(i) has rendered the health care service to the covered individual; and

(ii) has the assignment of benefits;

the insurer shall make a benefit payment directly to the provider for the health care service and send written notice of the payment to the covered individual or the authorized representative of the covered individual.

(b) An insurer is not required to make a benefit payment directly to a provider described in subsection (a) if the provider has been convicted of fraud.

(c) This section does not require:

(1) coverage for benefits not covered under the terms of a policy; or

(2) payment to a provider that is not eligible for a benefit payment under the terms of a policy.

Sec. 7. If:

(1) a provider is entitled to a direct benefit payment under section 6 of this chapter;

(2) the insurer makes the benefit payment directly to the covered individual or the authorized representative of the covered individual rather than to the provider; and

(3) the provider notifies the insurer that the provider has not received the benefit payment;

the insurer, not more than thirty (30) days after receiving the notice from the provider, shall make the benefit payment directly to the provider.

Sec. 8. If:

(1) a provider is entitled to a direct benefit payment under section 6 of this chapter; and

(2) there is a good faith dispute regarding the:

(A) legitimacy of the claim relating to the health care service rendered;

(B) appropriate amount of reimbursement for the claim; or

(C) authorization for the assignment of benefits;

the insurer, not more than fourteen (14) business days after the insurer receives the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the provider or the provider's authorized representative.

Sec. 9. (a) Except as provided in subsection (c), a provider that has not entered into an agreement with an insurer under IC 27-8-11-3 or the provider's agent shall disclose to a covered individual the following applicable information:

(1) That the provider has not entered into an agreement with the insurer to provide health care services to the covered individual.

(2) That the covered individual may be billed for health care services for which payment is not made by the insurer.

(b) A disclosure required by subsection (a) must be:

(1) made in writing; and

(2) if included in a document containing consent for treatment, displayed conspicuously.

(c) A disclosure is not required under subsection (a) if any of the following apply:

(1) The patient is unconscious, incoherent, or incompetent.

(2) The patient:

(A) arrives at a hospital required to provide emergency medical screening or care under 42 U.S.C. 1395dd; and

(B) seeks emergency medical screening or care.

(3) The provider does not know and could not reasonably know that the patient is covered under a policy issued by an insurer with which the provider has not entered into an agreement for the delivery of health care services.

(4) The provider has been requested to render health care services to the covered individual after the covered individual has been admitted for inpatient or outpatient services and the provider's services were not part of the original treatment plan.

Sec. 10. (a) An insurer that does not comply with this chapter

shall pay interest for each day of noncompliance at the same interest rate as provided in IC 12-15-21-3(7)(A).

(b) IC 27-8-5.7 applies to payment of a claim submitted to an insurer by a provider in compliance with this chapter.

Sec. 11. A provider, by accepting an assignment of benefits under this chapter, does not agree to accept an insurer's fee schedule or specific payment rate as payment in full, partial payment, or appropriate payment.

Sec. 12. A policy provision or contract provision that violates this chapter is void.

SECTION 2. IC 27-13-36.3 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2009]:

Chapter 36.3. Assignment of Benefits

Sec. 1. As used in this chapter, "assignment of benefits" means a written instrument that:

(1) is executed by an enrollee or the authorized representative of an enrollee; and

(2) assigns to a nonparticipating provider the enrollee's right to receive reimbursement for health care services provided to the enrollee.

Sec. 2. As used in this chapter, "health care services" includes ambulance services.

Sec. 3. As used in this chapter, "health maintenance organization" includes a limited service health maintenance organization.

Sec. 4. As used in this chapter, "nonparticipating provider" means a provider that has not entered into an agreement described in IC 27-13-1-24.

Sec. 5. As used in this chapter, "provider" includes an ambulance service provider.

Sec. 6. (a) Except as provided in subsection (b), if:

(1) an individual contract or a group contract provides coverage for a health care service;

(2) the health care service is rendered by a nonparticipating provider; and

(3) the nonparticipating provider:

(A) has an assignment of benefits from the enrollee to whom the health care service is rendered; and

(B) provides written or electronic notification to the health maintenance organization that the nonparticipating provider:

(i) has rendered the health care service to the enrollee; and

(ii) has the assignment of benefits;

the health maintenance organization shall make a benefit payment directly to the nonparticipating provider for the health care service and send written notice of the payment to the enrollee or the authorized representative of the enrollee.

(b) A health maintenance organization is not required to make a benefit payment directly to a nonparticipating provider described in subsection (a) if the nonparticipating provider has been convicted of fraud.

(c) This section does not require:

(1) coverage for benefits not covered under the terms of an individual contract or a group contract; or

(2) payment to a nonparticipating provider that is not eligible for a benefit payment under the terms of an individual contract or a group contract.

Sec. 7. If:

(1) a nonparticipating provider is entitled to a direct benefit payment under section 6 of this chapter;

(2) the health maintenance organization makes the benefit payment directly to the enrollee or the authorized representative of the enrollee rather than to the nonparticipating provider; and

(3) the nonparticipating provider notifies the health maintenance organization that the nonparticipating provider has not received the benefit payment;

the health maintenance organization, not more than thirty (30) days after receiving the notice from the nonparticipating provider, shall make the benefit payment directly to the nonparticipating provider.

Sec. 8. If:

(1) a nonparticipating provider is entitled to a direct benefit payment under section 6 of this chapter; and

(2) there is a good faith dispute regarding the:

(A) legitimacy of the claim relating to the health care service rendered;

(B) appropriate amount of reimbursement for the claim; or

(C) authorization for the assignment of benefits;

the health maintenance organization, not more than fourteen (14) business days after the health maintenance organization receives

the claim and all documentation reasonably necessary to determine claim payment, shall provide notice of the dispute to the nonparticipating provider or the nonparticipating provider's authorized representative.

Sec. 9. (a) Except as provided in subsection (c), a nonparticipating provider or the nonparticipating provider's agent shall disclose to an enrollee the following applicable information:

(1) That the provider is not a participating provider.

(2) That the enrollee may, subject to IC 27-13-36-5 and IC 27-13-36-9, be billed for health care services for which payment is not made by the health maintenance organization.

(b) A disclosure required by subsection (a) must be:

(1) made in writing; and

(2) if included in a document containing consent for treatment, displayed conspicuously.

(c) A disclosure is not required under subsection (a) if any of the following apply:

(1) The patient is unconscious, incoherent, or incompetent.

(2) The patient:

(A) arrives at a hospital required to provide emergency medical screening or care under 42 U.S.C. 1395dd; and

(B) seeks emergency medical screening or care.

(3) The provider does not know and could not reasonably know that the patient is covered under an individual contract or a group contract entered into by a health maintenance organization for which the provider is not a participating provider.

(4) The provider has been requested to render health care services to the enrollee after the enrollee has been admitted for inpatient or outpatient services and the provider's services were not part of the original treatment plan.

Sec. 10. (a) A health maintenance organization that does not comply with this chapter shall pay interest for each day of noncompliance at the same interest rate as provided in IC 12-15-21-3(7)(A).

(b) IC 27-13-36.2 applies to payment of a claim submitted to a health maintenance organization by a nonparticipating provider in compliance with this chapter.

Sec. 11. A nonparticipating provider, by accepting an assignment of benefits under this chapter, does not agree to accept a health maintenance organization's fee schedule or specific payment rate as payment in full, partial payment, or appropriate

payment.

Sec. 12. A contract provision that violates this chapter is void.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1086, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Delete everything after the enacting clause and insert the following:

(SEE TEXT OF BILL)

and when so amended that said bill do pass.

(Reference is to HB 1086 as introduced.)

FRY, Chair

Committee Vote: yeas 6, nays 5.